STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING: <b>01</b>		(X3) DATE SURVEY COMPLETED		
		HAL034016	B. WING		07/2	2/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
VIENNA VILLAGE 6601 YADKINVILLE ROAD PFAFFTOWN, NC 27040						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
C 000	Initial Comments		C 000			
	Harrell and Bob Ge Records indicate th was first licensed of Aged on 3-1-1966. facility must meet th Code, the 1971 Min and Regulations for Infirm and the appli Rules for the Licens Seven or More Bed The right end of the therefore must mee Code, the 1984 and 2005 Rules for the Homes of Seven or The left end of the f must meet the 2006	e facility was built in 1985 and et the 1978 NC State Building d applicable portions of the Licensing of Adult Care				
	Homes of Seven or currently licensed for	More Beds. The facility is or 90 residents.				
	Deficiencies were n of correction.	oted which will require a plan				
C 101	Existing Licensed F	ac- No less than '71 Rules	C 101			
	PHYSICAL PLANT The physical plant r care home shall be (2) Except where of licensed facilities or facilities shall meet	01 APPLICATION OF REQUIREMENTS requirements for each adult applied as follows: otherwise specified, existing reportions of existing licensed				

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING: <b>01</b>		(X3) DATE SURVEY COMPLETED	
		HAL034016	B. WING		07/2	22/2015
	PROVIDER OR SUPPLIER	6601 YAD	DRESS, CITY, S KINVILLE RO WN, NC 270			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
C 101	renovation, or alterathe requirements for no addition or renovation than those requirements for additions. The segulations of the segulation of the seguing the segulation of the seg	or bed count, addition, ation; however in no case shall or any licensed facility where vation has been made, be less ments found in the 1971 ired Standards and omes for the Aged and Infirm", available at the Division of ulation, 701 Barbour Drive, plina, 27603 at no cost; et as evidenced by: on, portions of the facility that 09, were not in compliance 1.1 of the 2006 NC State ction 302.1.1.1 requires doors areas" to be resistant to the	C 101			
C 144	SECTION .0300 - F 10A NCAC 13F .03 ENVIRONMENT (f) The requiremen closets are: (5) Handwashing fa	ts for storage rooms and acilities with wrist type lever byided immediately adjacent	C 144			

Division of Health Service Regulation STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				ATE SURVEY DMPLETED	
		HAL034016	B. WING		07/2	2/2015	
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 0172		
VIFNNA	VILLAGE		KINVILLE R				
VIEINIA			WN, NC 270				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPERTION OF THE APPROPERTIES OF THE A	D BE	(X5) COMPLETE DATE	
C 144	Continued From pa	ge 2	C 144				
	handwashing sink preperation area wa	on, the faucet on the provided in the medication as not equipped with lever e to operate the faucet without					
C 189	Building Equipment	Maintained Safe, Operating	C 189				
	mechanical, and plu care home shall be operating condition (k) This Rule shall facilities with the ex	11 OTHER  d all fire safety, electrical, umbing equipment in an adult maintained in a safe and					
	fire rated walls and, in several locations are not sealed with one-hour fire rated possibility that a fire quickly spread to of Findings include:  a. Unsealed penetithrough the ceiling of b. Unsealed peneticeiling of linen close 2. Based on observations	vation, the required one-hour for ceilings were compromised. Holes and penetrations that materials approved for use in construction present the exthat begins in one space can ther areas of the facility.  Tation at a threaded rod of the sprinkler riser room, ration at wires through the					

Division of Health Service Regulation STATE FORM

6899 1HLZ21 If continuation sheet 3 of 5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED	
		HAL034016	B. WING		07/2	2/2015	
NAME OF PROVIDER OR SUPPLIER STREET ADD			DRESS, CITY, S	STATE, ZIP CODE			
VIENNA	VILLAGE		KINVILLE RO WN, NC 270				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION DEFICIENCY)	D BE	(X5) COMPLETE DATE	
C 189	Hole through the do	vation, the exhaust system for om was not maintained in a dition.  ad disconnected in the attic in for the ice machine room.  de Elec. Heaters Prohibited  PHYSICAL PLANT  11 OTHER  a heating system sufficient to s F (24 degrees C) under tions. In addition, the y to heaters and cooking  purning room heaters and atters are prohibited.  apply to new and existing ception of Paragraph (e) ly to existing facilities.  et as evidenced by: on, the facility was not e condition as relates to	C 189				
	off the Supervisor's	neater was found in the closet office. vas removed during the					
C 150	Exit Doors Locks S  IV. The Building C. Physical Enviro	onment (10 NCAC 42D .1503)	C 150				

Division of Health Service Regulation STATE FORM

1HLZ21 If continuation sheet 4 of 5

If continuation sheet 5 of 5

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED	
		HAL034016	B. WING		07/2	2/2015
NAME OF				STATE, ZIP CODE		
VIENNA	VILLAGE		KINVILLE R WN, NC 27(			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
C 150	8. Outside Entranc. All exit doors loby a single hand me times without keys. locking device which this standard.)  This Rule is not me Based on observation of the facility license motions to operate requiring more thandelay an evacuation Finding includes: An exit door was fo deadbolt requiring of	cices/Exits cicks must be easily operable, otion, from the inside at all (This limits each door to one th meets the criteria set forth in et as evidenced by: on, an exit door in the portion ed in 1984 required 2 hand and open. Exit doors in one operation to open could	C 150			

6899

Division of Health Service Regulation STATE FORM